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PEDIATRIC PATIENT MEDICAL HISTORY FORM

Date	Child's Name	Nickname	DOB	M F

Previous Physician	Request for Records Transfer Complete Y N	Date of Last Well Child Exam

Mother's Full Name	Father's Full Name
Step-Mother's Full Name (If Applicable)	Step-Father's Full Name (If Applicable)
Custodial Provider's Full Name (If different from above)	Relationship to Patient

Birth History

Birth Weight _____ Preg#_____ Mom's age_____ Was the birth □ Vaginal ? □ Cesarean? □ Early? □ Late?
If birth was early, how many weeks early? _____ If Cesarean, why? _____
Did mother have any illnesses/problems with her pregnancy? □ Yes □ No Explain _____
Did baby have any problems right after birth? □ Yes □ No Explain_____

Before mother knew she was pregnant or at any time during her pregnancy did she:
□ Smoke Cigarettes (amount)_____ □ Drink Alcohol (amount) _____
□ Use "street" drugs (type)_____ □ Use Prescription Drugs (type)_____

Was feeding □ Breast Milk? □ Formula? Or Both?

Current and Past History

Is your child currently on any medication?	□ Y	□ N	Explain_____
Does your child have any serious or chronic illnesses?	□ Y	□ N	Explain_____
Has your child had serious injuries or accidents?	□ Y	□ N	Explain_____
Has your child had any surgeries?	□ Y	□ N	Explain_____
Has your child ever been hospitalized?	□ Y	□ N	Explain_____
Is your child allergic to any medications?	□ Y	□ N	Explain_____
Has your child ever reacted to immunizations?	□ Y	□ N	Explain_____

Patient Health History (past or present)

Asthma, recurrent cough, bronchitis, or pneumonia	□ Y	□ N	Explain_____
Nasal allergies or eczema	□ Y	□ N	Explain_____
Frequent ear infections or sore throat	□ Y	□ N	Explain_____
Problems with ears or hearing	□ Y	□ N	Explain_____
Problems with eyes, vision or teeth	□ Y	□ N	Explain_____
Frequent headaches or other neurologic problems	□ Y	□ N	Explain_____

Frequent abdominal pain	□ Y	□ N	Explain_____
Constipation requiring doctor visits	□ Y	□ N	Explain_____
Bladder/kidney problems or bedwetting	□ Y	□ N	Explain_____
Any heart problems/murmur	□ Y	□ N	Explain_____
Anemia or bleeding problem	□ Y	□ N	Explain_____
Thyroid or other gland problem	□ Y	□ N	Explain_____
Diabetes	□ Y	□ N	Explain_____
ADD/ADHD	□ Y	□ N	Explain_____
Mental Health Issues	□ Y	□ N	Explain_____
Use of drugs or alcohol	□ Y	□ N	Explain_____

Household Information

Pease List All Those Living in the Child's Home

Name	Relationship to Child	Age

Are there siblings not listed above? If so, please list their full names and ages and where they live. _____
_____
_____

Child Care:_____

Smokers in household? □ Y □ N

Family Medical History (Parents, Siblings, Grandparents, Aunts and Uncles)

Have Any Family Members Had the Following:

Alcohol/Drug Abuse: □ Y □ N Who_____ Comments_____

Allergies: □ Y □ N Who_____ Comments_____

Asthma: □ Y □ N Who_____ Comments_____

Birth Defects: □ Y □ N Who_____ Comments_____

Blood Disorders: □ Y □ N Who_____ Comments_____

Bone Disorders: □ Y □ N Who_____ Comments_____

Cancer: □ Y □ N Who_____ Comments_____

Diabetes: □ Y □ N Who_____ Comments_____

Endocrine Disease: □ Y □ N Who_____ Comments_____

Ear/Nose/Throat: □ Y □ N Who_____ Comments_____

Eye Disorders: □ Y □ N Who_____ Comments_____

Gastrointestinal Disorders: □ Y □ N Who_____ Comments_____

Heart Disease: □ Y □ N Who_____ Comments_____

High Blood Pressure: □ Y □ N Who_____ Comments_____

High Cholesterol: □ Y □ N Who_____ Comments_____

Immune Disorders: □ Y □ N Who_____ Comments_____

Joint Problems: □ Y □ N Who_____ Comments_____

Kidney Disease: □ Y □ N Who_____ Comments_____

Liver Disease: □ Y □ N Who_____ Comments_____

Lung Disease: □ Y □ N Who_____ Comments_____

Mental Health History: □ Y □ N Who_____ Comments_____

Migraine Headaches: □ Y □ N Who_____ Comments_____

Metabolic Disorders: □ Y □ N Who_____ Comments_____

Obesity: □ Y □ N Who_____ Comments_____

Seizure Disorders: □ Y □ N Who_____ Comments_____

Skin Disorders: □ Y □ N Who_____ Comments_____

Stroke History: □ Y □ N Who_____ Comments_____

Thyroid Disorders: □ Y □ N Who_____ Comments_____

Other Medical History □ Y □ N Who_____ Comments_____

Other Medical History □ Y □ N Who_____ Comments_____

X _____